Kentucky Department for Medicaid Services (DMS)
Lock-In Recipient Referral

Date of Referral: _____

This authorizes _____
(Provider to whom lock-in recipient is referred)

to only provide _____
(Description of service (e.g., consultation, office visit, pain management, surgery)

to _____ ID # _____
(Name of Medicaid Lock-In Recipient) *(Medicaid ID # of Recipient)*

for symptoms and conditions of _____

Referred-to physician: Please contact my office at ____ - _____- _____-x_____to forward lab results and consultation information and/or to make prescribing recommendations for additional services that may be medically necessary for this particular recipient (e.g., non-emergency diagnostic procedures, medical supplies, prescription drugs, surgical procedures).

Authorized Date(s) of Service _____ to _____

Designated Primary Care Provider Signature _____Date: _____

Designated Primary Care Provider's NPI # _____

(*The Designated Primary Care Provider's NPI # is required in the " referring provider" field of the claim submitted for reimbursement to the Kentucky Department for Medicaid Services.*)

Designated Primary Care Provider: One (1) copy of this referral shall be retained in the Lock-In Recipient's file and one (1) copy shall be sent to the referred provider. Upon request, the Lock-In Recipient should be provided one (1) copy of this referral.

Any questions relating to this form may be forwarded to the Lock-in Case Manager at the following:
Telephone # 877-298-6108 Fax: 502-209-5222